Substance Abuse and Mental Health Services Administration
40th Meeting of the SAMHSA National Advisory Council

Minutes

Thursday, June 29, 2006

The Substance Abuse and Mental Health Services Administration (SAMHSA) National Advisory Council convened for its 40th meeting on June 29, 2006, at SAMHSA headquarters in Rockville, Maryland. Charles G. Curie, M.A., A.C.S.W., Administrator, SAMHSA, chaired the meeting.

Council Members Present: Council Co-Chair James R. Aiona, Jr. (by telephone), Faye Annette Gary, Ed.D., R.N., Diane Holder, Barbara Huff, Thomas A. Kirk, Jr., Ph.D., Theresa Racicot, Kenneth D. Stark and Kathleen Sullivan

Council Members Absent: Columba Bush and Gwynneth A. E. Dieter.

Ex-Officio Member Present: Laurent S. Lehmann, M.D.

Council Executive Director: Daryl W. Kade, M.A.

Council Executive Secretary: Toian Vaughn, M.S.W.

SAMHSA Staff Present: Kathryn A. Power (Director, Center for Mental Health Services), Dennis Romero (Acting Director, Center for Substance Abuse Prevention), and H. Westley Clark (Director, Center for Substance Abuse Treatment).

Non-SAMHSA Federal Staff Present: 3 individuals (see Tab B for Federal Attendees List).

Representatives of the Public Present: 22 individuals (see Tab B for Public Attendees List).

THURSDAY, JUNE 29, 2006

Welcome and Opening Remarks

SAMHSA Administrator Charles G. Curie called the Council meeting to order at 9:20 a.m. and welcomed attendees. He announced the resignation of Thomas Lewis from the Council due to health and family concerns and acknowledged his role in advocating for individuals with mental illness and addictive disorders as well as his dedicated service to the Council. Ms. Columba Bush and Mrs. Gwynneth Dieter were not able to attend due to scheduling conflicts. Mr. Curie remarked that the Council orientation session, that was held a day earlier, offered opportunities for insight into SAMHSA programs and helped to introduce the leadership team. New additions to SAMHSA's leadership team include Acting Deputy Administrator Dr. Eric B. Broderick, Dr. Larke Huang (the new "children's czar"), and SAMHSA Senior Advisor to the Administrator, Mr. Arne Owens, whose duties include veterans issues and community- and faith-based initiatives within SAMHSA, and the offices of HHS and the White House.

Mr. Curie acknowledged the presence of Dr. Westley Clark, Director, Center for Substance Abuse Treatment (CSAT), Mr. Dennis Romero, Acting Director, Center for Substance Abuse Prevention (CSAP) and Mr. Ted Searle, Deputy Director, Center for Mental Health Services (CMHS) representing CMHS Director Ms. Kathryn Power.

Administrator's Report

Mr. Curie announced that he has submitted his resignation as SAMHSA Administrator to the President, effective August 5, 2006, and acknowledged that he was inspired by the participation of Council members and SAMHSA's constituency groups, their passion, value system, and assuring that people find their voice. He stated that the mission of building resilience and facilitating recovery remains unrealized until outcomes in people's lives include finding their own voices and making lives in the community.

Mr. Curie reviewed SAMHSA's agenda of priorities and highlighted selected achievements at SAMHSA during his stewardship:

- Alignment and leveraging of resources around priorities, using the SAMHSA Matrix;
- Influential Centers within SAMHSA, to which people look for direction and resources, and the Office of Applied Studies, which helps inform the field;
- Focus on consumer- and family-driven systems, synthesizing diverse input to enable wise investment of resources consistent with Administration goals as set forth by the SAMHSA Council and constituency groups;
- Increased accountability to investors, the Congress, the White House, HHS, and constituency groups;
- Focus on resilience and recovery and on operationalizing recovery from public policy and public finance standpoints;
- Leveraging systemic changes in Centers' initiatives resulting in increased engagement of community- and faith-based providers in Access to Recovery (ATR) and the New Freedom Initiative (NFI);
- Implementation of the data strategy through the creation of National Outcome Measures and State Outcome Measures and Management Systems;
- Increased focus on reducing time lags in the science-to-service agenda;
- Development of a platform to inform the field through the National Registry of Evidence-Based Programs and Practices (NRREP) for both prevention and treatment;
- CMHS's development of the National Consensus Statement on Mental Health Recovery;
- CMHS's leadership in convening more than 20 Federal agencies to develop the Federal Action Agenda for Mental Health System Transformation and State Incentive Grants for Mental Health Transformation;
- Implementing (ATR) infrastructure change, which empowers States and tribal organizations to offer an increased and broader choice of services;
- Implementation of the 2002 Co-occurring Report to Congress, recognizing that treatment of people with co-occurring mental illness and addiction disorders should be the expectation, and sustainable treatment must address both;
- Increased efforts to bring prevention to scale on a national level, including the incorporation of SAMHSA's Strategic Prevention Framework (SPF) into the Federal Helping America's Youth Initiative; implementation of SPF in 40 States;

- The dissemination of tools such as Communities That Care, provides science-based decisions to States to assess protective factors and provide implementation strategies;
- Empowering local communities with information and resources in recognition of their abilities to best solve local substance abuse problems;
- Reduction in illicit drug use among youth by 19 percent since 2002 is a tribute to stakeholders who operate with a more unified approach;
- Increased focus on workforce development recognizing its critical connection to service quality improvement;
- Continued efforts on suicide prevention, the reduction and elimination of coercion, seclusion and restraint practices, and underage drinking; and,
- Developing mental health and substance abuse modules in disaster plans in collaboration with States.

Mr. Curie urged SAMHSA to continue international work in promoting recovery and working with post-conflict developing countries. He reiterated his belief that mental health and substance abuse are central to public health and urged Council members to continue serving as SAMHSA's ambassadors.

Council Discussion

Council members unanimously thanked Mr. Curie for his leadership contributions. Mr. Kenneth Stark thanked Mr. Curie for his strong leadership with SAMHSA and observed that his long-standing legacy will be the use of the NOMS and the ability to measure States' outcomes and provide consistency across State and Federal entities. He suggested that SAMHSA encourage the three research institutes at the National Institutes of Health (National Institute of Mental Health, National Institute on Drug Abuse, and National Institute on Alcohol Abuse and Alcoholism) to collaborate with States and use them as laboratories for service research.

Ms. Kathleen Sullivan thanked Mr. Curie for respecting and honoring consumers. Ms. Barbara Huff expressed her appreciation that Mr. Curie has included advocates on the Council to provide input. She expressed her hope that future administrators will continue to include on the Council advocates who are family members.

Dr. Faye Gary observed that the new focus on workforce development will shape how all other priorities on the Matrix will be addressed. She urged SAMHSA and other research institutes to investigate poverty as a risk factor for mental illness and substance abuse, and to consider early interventions. She also urged thinking about a "cure" for mental illness and adding the word to SAMHSA's vocabulary.

Mr. "Duke" Aiona observed that to make a difference in communities, people must engage in dialogue and collaboration, and weather the inevitable conflicts and challenges that accompany change. He also emphasized the importance of SPF in outcome measurement. Mr. Curie thanked Mr. Aiello for his service as Council co-chair and noted the importance of elected officials advocating for prevention and treatment.

Dr. Thomas Kirk asserted that Mr. Curie's greatest legacy is the vision and agenda of change that he set for SAMHSA around substance abuse and mental health issues, and for his work in

forging partnerships to promote recovery and creating hope and empowerment for people with mental illnesses and substance abuse disorders—thus creating a natural advocacy.

Dr. Laurent Lehman stated that the President's New Freedom Commission on Mental Health helped to move the Department of Veterans Affairs (VA) toward recovery and rehabilitation. He acknowledged SAMHSA's lead in a conference for community and state mental health leaders on how to deal with disasters post September 11, 2001 and in the March 2006 conference on returning veterans.

Mr. Curie acknowledged SAMHSA's work in that field and further noted the Agency's efforts post September 11 in working with States to develop a mental health and substance abuse consequence module to add to their disaster plans.

Consideration of the Minutes from the December 6-7, 2005, Council Meeting

The minutes of the December 6-7, 2005 Council meeting were approved unanimously as submitted.

Leadership to Keep Children Alcohol Free Initiative

Ms. Michele Ridge, Leadership Foundation member and former First Lady of Pennsylvania, explained that the Leadership to Keep Children Alcohol Free Initiative (Initiative) relies on establishing a social capital that promotes networking and relationships building to meet its goals. In 1999, NIAAA and the Robert Wood Johnson Foundation invited the spouses of State Governors to join a coalition of Federal agencies and public and private organizations to prevent the use of alcohol by children ages 9 to 15. In March 2000, the Initiative was launched and approximately 20 governors' spouses took the pledge to ensure that the prevention of early alcohol use by children is recognized as a priority concern for the nation and to educate the public about the dangers posed by such early use.

Ms. Ridge noted that the science behind the Initiative gives the governors' spouses the credibility to recruit their respective State agencies, advocacy groups, parent groups, and others to address underage drinking. The Initiative has sponsored conferences and regional meetings, developed a website (alcoholfreechildren.org), enlisted partners, and worked with the health care field and scientific advisory groups. Ms. Ridge indicated that the success of the Initiative is reflected in the non-partisan approach by the States on this issue. The group's work has leveraged action by others and put a public face on the matter of childhood drinking. Ms. Ridge offered statistics from the Centers for Disease Control and Prevention's (CDC) 2005 Youth Risk Behavior Surveillance survey revealing that 71 percent of Americans age 10-24 die from car crashes, injuries, homicide, and suicide, with alcohol involved in more than 40 percent of the incidents; and, of children who drink regularly under age 14, 40 percent will have alcohol addiction issues to deal with as adults.

Ms. Theresa Racicot, SAMHSA National Advisory Council member, former First Lady of Montana, and Leadership to Keep Children Alcohol-Free Foundation president, noted that, in addition to its current 40 sitting members, the Initiative now includes 18 emeritus spouses who are very involved and committed to the issue. The sitting spouses have advocated for the Surgeon General's Call to Action, worked on SAMHSA's town hall meetings, supported the

Institute of Medicine's recommendations, and maintained strong relationships with a broad spectrum of organizations. Important focuses include consideration of the cost of childhood drinking related to law enforcement and justice, and potential for a program of primary care screening. With Federal funding expiring in 2007, the Initiative formed the bipartisan Leadership Foundation to develop continuing funding sources.

Council Discussion

Ms. Diane Holder noted the importance of confronting the idyllic national misperception that children are protected through education and the enlistment of cooperating pediatricians. In response to Ms. Holder's question, Ms. Ridge noted that engagement of schools varies by State and typically is driven by parent organizations. Ms. Racicot added that each spouse sets a unique agenda and acknowledged Columba Bush's leadership as co-chair of the Initiative.

Ms. Huff likened the Initiative with one undertaken by congressional spouses who advocated successfully for Systems of Care for children's mental health and permitted the issue to rise to the surface and for legislation to pass.

Mr. Stark asked whether the initiative has been involved in model legislation to promote prevention activities and reduce access. Ms. Ridge noted that some States have passed key registration legislation, but activity levels vary by State. Ms. Racicot noted that high school students lobbied successfully for key registration in Wyoming.

Dr. Gary observed the usefulness of other groups as members of the network, including the juvenile justice system, school systems, faith-based organizations, and others. Ms. Ridge responded that in individual States, most governors' spouses have brought community groups together, to which the Initiative provides considerable evidence-based programming materials and technical assistance.

To another question from Dr. Gary, Ms. Racicot responded that there is no scientifically-based evaluation process, however, one measure of the Initiative's success can be evaluated by the amount of materials requested and disseminated to 40 countries and nationally around town hall meetings. Mr. Aiona echoed concern about sustainability and attributed Hawaii's aggressive campaign to the motivation and support of the Initiative.

SAMHSA's International Activities

Mr. Curie stated that SAMHSA's mission focuses primarily on domestic issues, with no funds appropriated for international programs. Nevertheless, exposure to international issues has promoted learning from other countries, and the United States (U.S.) has provided technical assistance as countries develop their substance abuse and mental health services delivery system. A current focus is rebuilding the mental health services infrastructure in post-conflict Iraq and Afghanistan. Mr. Curie described the approach of the Iraqis as one that integrates mental health with primary health care, which is a direction that is gaining momentum within the United States. Afghanistan has set up a challenging 10-point plan that mirrors the work-in-progress in Iraq. Mr. Curie further acknowledged the unique stressors affecting the Iraqi mental health team where they are the target for insurgency and kidnapping.

Ms. Winnifred Mitchell-Frable, International Officer, SAMHSA, explained that this round of health diplomacy focuses on the common ground of improving mental and behavioral health and addressing service needs. In its international work, SAMHSA collaborates with the United Nations Office on Drugs and Crime in Central America. Additionally, SAMHSA is working to reestablish its efforts in Russia on substance abuse prevention and primary care screening as an HIV detection tool. SAMHSA staff also work in Vietnam and in Geneva on World Health Organization (WHO) mental health matters.

A planning group for Iraq includes staff from SAMHSA, National Institute of Mental Health (NIMH), National Institute on Drug Abuse (NIDA), the HHS Office on Global Health, the Departments of Defense and State, as well as Iraqi mental health advisors and colleagues in the United Kingdom. The group conducts biweekly conference calls for technical assistance and as a mentoring device. An action planning conference in Jordan in 2005 led to recommendations to institute a referral system which was institutionalized in 3 provinces, and to develop a code of practice for mental health. In 2006, at the Cairo conference, rival factions worked together to develop recommendations that built upon the work started in Amman. Ms. Mitchell-Frable noted that the effort is carried by Iraqi expatriates, Iraqis and other diplomats, and the WHO. She added that SAMHSA is recognizing and plans to support emerging leaders by providing them with training opportunities.

SAMHSA also established a workgroup for Afghanistan's mental health system. In Kabul in May 2006, people who work in mental health around the country, non-governmental agencies, and other funding partners convened for the first time. They developed a series of lessons learned, including the need for ongoing support and supervision in addition to short-term training; the challenge of finding and retaining staff; recognizing the vulnerable status of women and children; and the universal experience of violence and trauma. Challenges include defining standards for interventions, determining how to screen and provide substance abuse services, and limited public awareness of substance abuse and mental health problems. The group recommended building human capacity, integrating behavioral health into primary care, and increasing public awareness. Next steps in Afghanistan and Iraq are to provide targeted support for implementation of national strategic plans and support for training and emerging leaders. Ms. Mitchell-Frable emphasized that, in Afghanistan, there is hope and the opportunity to integrate mental health into primary care. WHO and other nongovernmental organizations will participate in the effort, and cultural competence will be an important skill.

Council Discussion

Ms. Mitchell-Frable responded to a question from Ms. Huff that consumer advocacy organizations participate in both Iraq and Afghanistan. To a question from Ms. Sullivan, Ms. Mitchell-Frable and Mr. Curie acknowledged that Iraqi health workers face significant risks.

SAMHSA's Access to Recovery Program: Update

Mr. Curie stated that during the first three-year cycle, the presidential initiative Access to Recovery (ATR) is implemented in 14 States and 1 tribal organization. Congress and others in the field have expressed interest in ATR's outcomes, and data appears highly encouraging in terms of more people receiving access to treatment, care, recovery, and recovery support services. Nevertheless, ATR's future remains in question.

CSAT Director, H. Westley Clark, explained that the voucher-based ATR program focuses on recovery and emphasizes consumer choice, accountability, and effectiveness. ATR aims to address the treatment gap and expand access to care by ensuring a client's choice for clinical treatment and recovery support services at the appropriate level of care. Dr. Clark stated that ATR provides for a significant level of outreach to a wide range of service providers that have not previously received funding, such as community- and faith-based organizations, thus expanding opportunities for care. He emphasized that community support is inextricably linked to recovery, and noted that holistic support may contribute cumulatively to a person's recovery.

Dr. Clark reviewed ATR's status through March 2006 and indicated that: (1) all grantees had uploaded data; (2) more than 62,000 clients were served (26 percent more than projected); (3) more than 56 percent of clients for whom status and discharge data are available have received recovery support services; (4) 43 percent of the value of redeemed vouchers was redeemed for recovery support services; (5) outcome measures on abstinence, employment, social connectedness, criminal justice involvement, and stable housing by discharged were positive; (6) faith-based organizations redeemed about 30 percent of the ATR expended dollars for clinical and recovery support services, or about $48 million; and (7) faith-based organizations accounted for approximately 21 percent of all recovery support service providers and 33 percent of clinical treatment providers that redeemed vouchers.

Dr. Clark summarized the activities and accomplishments of each of the 15 grantees, some of which are highlighted below:

- California's surveys indicate high client satisfaction with CARE services that connect youth in juvenile facilities to recovery support services during and after incarceration.
- The California Rural Indian Health Board's (CRIHB) use of online enrollment of clients and distribution of vouchers has significantly reduced time requirements for these activities.
- Idaho has exceeded by 53 percent its target number of clients served by outreaching to residents of many rural communities and by providing culturally sensitive services to Native Americans and Hispanic communities.
- Louisiana exceeded its target for clients served by 38 percent and recently added outpatient treatment with buprenorphine services as another clinical service.
- New Jersey plans to offer small funding opportunities to the New Jersey American Indian community and faith-based providers struggling to start or expand services.
- New Mexico increased the recovery support service voucher value and expanded services to include housing.
- Texas has conducted training for all enrolled providers and participating courts.
- Washington has established a strong collaboration with faith-based providers and partners who provide points of entry, housing, drug-free activities, and many more services.

- Wyoming's ATR has integrated effectively with existing mental health and substance abuse providers, thus expanding capacity, and has streamlined the approval process for new providers.

Dr. Clark identified some challenges of the ATR application, such as the need for ongoing support for peer leaders, ethics and risk management, coordination and collaboration with other systems of care, monitoring and evaluation, and sustainability. SAMHSA has provided technical assistance to grantees on screening/assessment and recovery support practices and services, methods to increase faith- and community-based organizations' participation, and financial management, plus more general assistance to grantees.

Dr. Clark announced that the future of ATR may be found in the President's $70 million proposal for Choice Incentive and Methamphetamine Programs where States and tribal organizations that voluntarily commit to using a portion of their block grant funds to deliver substance abuse treatment through vouchers would receive priority. Recipients could use up to 30 percent of their awards for technical support to convert their treatment systems to vouchers. Grantees would identify milestones, collect data, and document outcomes through NOMs.

The House Appropriations Committee has supported a $25 million methamphetamine program, with vouchers optional, that would focus on up to ten State grants where epidemiological and treatment data indicate high methamphetamine and treatment prevalence. SAMHSA would use methamphetamine funds to support clinical treatment, recovery support services, and increased focus on participation of community- and faith-based organizations.

Council Discussion

Ms. Sullivan asked the reason for a methamphetamine epidemic in Natrona, Wyoming and in Appalachia. Dr. Clark responded that the drug's use has swept across Western and Midwestern States, but that Wyoming and Tennessee chose to submit grant applications specifically addressing methamphetamine services while other jurisdictions address the problem as part of their overall efforts. He suggested a review of the methamphetamine problem at the next Council meeting.

Connecticut Access to Recovery

Commissioner Thomas A. Kirk, Jr., Ph.D., Department of Mental Health and Addiction Services (DMHAS), State of Connecticut, described his State's ATR program. The State uses recovery core values, elicited from the addiction advocacy community, as a template to measure its activities. Dr. Kirk considers substance abuse and mental health issues to be health care issues and the agency to be a health care service agency promoting value-driven sustained health and recovery through treatment and using collaborative tools for its recovery support services.

Dr. Kirk observed that the field must take some responsibility for stigma in terms of its language, for example, "serious and persistent mental illness" and "chronic, relapsing disease." Instead of its expensive acute-care orientation, the health care system should offer recovery-oriented continuity of care to bridge gaps between episodes of care, with recovery support services linked to the community to avoid repeat episodes. Data showed that Connecticut was under-treating or poorly treating significant numbers of people who went multiple times into detox or inpatient

psychiatric facilities. The agency's overarching goal is a value-driven recovery-oriented system that offers the highest quality of care at the most reasonable cost. Partnerships with the recovery community and other state agencies and collaborative funding sources are essential in providing tools to people in their recovery process.

Connecticut's ATR program meshes with its existing service system and builds on previous infrastructure activities. Through a Request for Proposal (RFP), Connecticut funds a substance abuse treatment network in each of its five regions. In the next couple of years, the State is mandated to re-bid the entire service system for an opportunity for funding. This would offer a way to ensure that ATR principles become the driving force in service delivery. The 165 providers offer a choice of peer, faith-based, and clinical approaches to recovery.

Dr. Kirk added that the Connecticut ATR program collaborates with a variety of judicial and social service agencies to engage people and intervene earlier in their substance use. It also funds Outreach and Engagement Urban Initiatives that bring value-sustained recovery services and support to people who are chronically homeless. Connecticut's ATR offers a range of clinical services, including a new focus on brief intervention and early-stage use, while other funding sources support residential treatment. Recovery support services include transportation, housing, vocational/educational services, tools, and vouchers for food, clothing, and personal care. Dr. Kirk observed that supportive housing decreases inpatient mental health and substance abuse costs and increases employment, and vocational training doubles the employment rate. These factors decrease the likelihood of acute care episodes and high repeat admissions. He offered several representative vignettes that describe various wraparound supports offered for people in need of services.

Dr. Kirk noted that faith-based communities serve as a significant source of new persons entering services, and the State's strong peer-based advocacy community provides mentoring and other community services. Two thirds of Connecticut's ATR funds go to recovery support services and not to clinical services. Connecticut's ATR program believes that this investment in recovery support services is necessary in that it addresses barriers, establishes an environment supportive of recovery, and provides the skills needed to initiate and build up recovery capital. Connecticut's program has served more than 10,000 people in two years, although a proper planning process delayed service provision and most people were served during year two. ATR received more than 75,000 service-level authorizations and paid claims of more than $10 million.

Challenges include the arduous task of developing an administrative infrastructure with providers to administer the voucher program, and that grassroots organizations lacked the experience in processing paperwork and GPRA recordkeeping. Lessons learned involve systems change, the need for technical assistance and certification for providers to collect required data, and inadequate attention to sustainability of recovery support services.

Next steps for Connecticut's ATR include re-credentialing all service providers for ongoing monitoring of quality of care, performance, and resource efficiency; considering a network approach as the basic framework for other funding streams; determining the comparative effectiveness of recovery support services; and considering expanding recovery support services into other funding sources.

Council Discussion

Mr. Curie thanked Dr. Kirk for envisioning ATR as a program that operationalizes recovery and makes access to recovery a real goal in people's lives. He also acknowledged the challenges of establishing a voucher program and encountering expected delays in service delivery.

Mr. Stark noted that Washington State's ATR program navigates an additional layer of government (counties and tribes) through which funds pass down to service providers. Concerns include control, accountability, and adequate staffing to implement the voucher system. Nevertheless, Washington State sees ATR as an opportunity for unprecedented flexibility to fill treatment gaps and provide recovery support services. Additional treatment expansion funds in year two permitted extending outreach and recovery support services into communities even before people entered treatment, using that mechanism to engage people to get additional treatment. In addition to traditional recovery support services, unique services included fixing a person's car, which was more cost-effective than paying for bus service to commute to treatment, and dental care for a bad toothache, which enabled the person to focus on his recovery plan. ATR provides flexibility and choices otherwise unavailable from traditional funding sources.

Mr. Stark expressed concern about the possible loss of ATR and his hope that other funding sources, such as the block grant, will become more flexible to enable the services to continue. Mr. Curie noted the importance of evaluating the overall efficacy and cost-effectiveness of recovery support services, particularly nontraditional services, which may offer shorter paths to achieving and sustaining recovery. He encouraged advocacy for ATR and reiterated Congress's interest in ATR outcomes.

In response to a question from Ms. Huff, Dr. Clark stated that while there is no comprehensive evaluation planned for ATR, SAMHSA evaluates outcomes by using the Government Performance and Results Act of 1993 (GPRA) data evaluation. Mr. Curie noted that ATR is the first treatment program to operationalize NOMs, which will enable evaluation in terms of attaining and sustaining recovery as defined by their 10 domains. The budget request includes $3 million for evaluation that is not present in the House mark. Mr. Stark observed that States must evaluate comparative outcomes for consumers assisted by ATR in order to justify sustaining the services on the basis of quality and cost. Dr. Kirk urged factoring continuity of care and quality of life into the evaluation equation.

Dr. Gary asked about access to ATR services by poor and underserved persons in jails and prisons upon their release. Dr. Kirk responded that most referrals originate from the probation, corrections, and parole systems, and that referrals are not as forthcoming from child welfare or juvenile justice. Mr. Stark noted that Washington State's ATR has targeted the child welfare system, and found that referral was a big challenge. Dr. Clark pointed out that in the aggregate, the criminal justice system is the largest point of referral in ATR, reflecting a well-established partnership. He noted that CSAT collaborates with the Departments of Justice and Labor to pair ATR grantees with their discretionary grant programs to promote reentry into the community.

Dr. Clark responded to Ms. Huff that ATR programs vary in their focus on serving young people. So, while California and Wyoming are funded for specifically targeting adolescents, other States have targeted a wider range of services and outcomes.

Council Roundtable

Mr. Stark urged SAMHSA to review evidence-based practice data for using PROMETA in light of the potential for political pressure on States to use it. Mr. Curie asked CSAT to take the matter under advisement, in partnership with NIDA, to evaluate how to inform States.

Public Comment

Ms. Thelma King Thiel, Chairman and CEO, Hepatitis Foundation International, noted that the foundation has trained 2,000 CSAT grantees on the liver-wellness approach for prevention and recovery. Upcoming studies find that the approach changes behaviors in programs for injection drug users and homeless children. The foundation plans to train 50 methamphetamine counselors at one university, and other schools have expressed interest. She urged SAMHSA to issue RFAs in order to streamline training people on the front lines.

Maj. Gen. Arthur T. Dean (Ret.), Chairman and CEO, Coalition of Anti-Drug Coalitions of America (CADCA), noted that collaboration between SAMHSA and CADCA's community coalitions has contributed to dramatic reductions in substance abuse. Together with CSAP, CADCA has published the first in a series of primers on the SPF to be used in all CADCA's training. Maj. Gen. Dean presented a plaque to Mr. Curie to recognize his leadership in the field and work with community coalitions.

Closing Remarks

Mr. Curie thanked members of the Council for their ongoing commitment, dedication, and support, in moving the agency's agenda ahead on behalf of persons with addictive diseases and mental illnesses, and youth at risk. He recognized the contributions of SAMHSA's leadership staff, including Ms. Daryl Kade, Associate Administrator for Policy, Planning and Budget, and Executive Director of SAMHSA's National Advisory Council; Ms. Toian Vaughn, Executive Secretary of SAMHSA's National Advisory Council; and Mr. Steve Wing, Associate Administrator for Alcohol Prevention and Treatment Policy.

Adjournment

The meeting adjourned at 3:20 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes and the attachments are accurate and complete.

_3/13/07_____ _____
Date

__/s/_____
Daryl Kade
Executive Director, SAMHSA National Advisory Council, and Associate Administrator for Policy, Planning and Budget, SAMHSA

Attachments:
Tab A – Roster of Members
Tab B – Attendees